MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

01824

Reg. Diat. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chimneys Neck

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Wright Ringold Calder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20 1878

8. AGE: Years	Months	Days	If less than one day
66	7	24	hrs. min.

9. Birthplace: Kent Co., Md. (Town, county, and state)

10. Usual occupation: retired fertilizer foreman

11. Industry or business: Pilot Point Sept

FATHER

12. Name: Robert R. Calder

13. Birthplace: Kent Co

MOTHER

14. Maiden name: Laura Rebecca Benjamin

15. Birthplace: Kent Co.

16. Informant: Mrs Fairbanks

Address: Rockhall, Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 2 17 45 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall Md.

18. Funeral director: Edgar L. Lane

Address: Clinch Hall Md.

19. 2/17, 1945 (Date rec'd by registrar) L. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1945 at 7 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1945, to Feb 13 1945 and that I last saw h[illegible] alive on 2-12 1945

Immediate cause of death	DURATION
Chron Endo-Myocarditis	
arteriosclerosis,	
Due to Coronary Sclerosis	
Subcompensation	
Due to Fracture of both feet	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

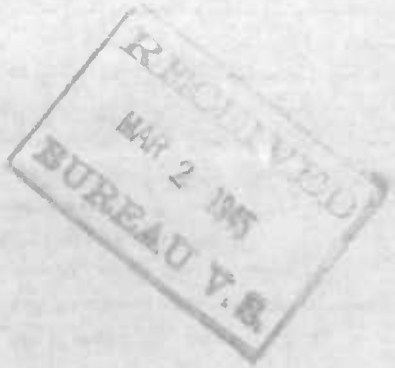
23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rockhall, Md. Date signed: 2/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAR 2 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01825

Reg. Dist. No. 201

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Kent County
Still Pond
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Kent
City or town Still zPond (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war World War "2"

3.(a) FULL NAME
Walter Galen Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug.21.1915

8. AGE: Years	Months	Days	If less than one day
29	5	17	..... hrs. ..... min.

9. Birthplace: Kent Co Md (Town, county, and state)
10. Usual occupation: Master Sgt. U.S.Army
11. Industry or business: U.S.Army

FATHER
12. Name: John Wm Clark
13. Birthplace: Kent CO Md

MOTHER
14. Maiden name: Mary E. Toulson
15. Birthplace: Kent Co Md

16. Informant: John Wm Clark (Father)
Address: Still Pond Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 9 1945 (month) (day) (year)
Cemetery or crematory: Still Pond
Location: Still Pond Md

19. Funeral director: B R Fellows
Address: Still Pond Md.

19. Feb 9 1945 (Date rec'd by registrar) J P Kelok Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb.7.1945 at 8.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend investigated and signed and that I last saw h..... alive on ..... 19..... Cerificate as Deputy Med. Exam. Kent Co

	DURATION
Immediate cause of death: Gunshot wound of ~~Head~~ Head	
Due to: Despondent	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of
Where did injury occur? Still Pond Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Gunshot Injured at work?

Earl Hales M.D
SIGNATURE
Deputy Med. Exam. Kent Co Md. Dr. or other
Address: Chestertown Md Date signed: 2.8.1945

Evidence for change of age of deceased is shown on FILM G94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01826

Reg. Dist. No. 200

1. PLACE OF DEATH:
County Kent
City or town Millington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Kent
City or town Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida L. Clough

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife George Clough
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 29/87

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Thomas J. Nickerson
13. Birthplace Maryland
MOTHER 14. Maiden name Verna Wood
15. Birthplace Md
16. Informant Eva Porter
Address Millington Md
17. Burial Date thereof Feb 28-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory [illegible]
Location [illegible]
18. Funeral director Edward Sellers
Address Millington Md
Feb. 24- 45 Merritt Brice
(Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22- 19 45, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2- 19 45, to Feb. 22 1945
and that I last saw h. alive on Feb. 22 19 45

Immediate cause of death	DURATION
Due to Carcinoma of Stomach, Mesh	1944
Due to Arthritis	4 Months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Merritt Brice M. D. or other
Address Millington Md Date signed 4-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

01827

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Esther O'Shauna Collins

3.(b) Social Security Number —

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife None
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Oct 24, 1944
8. AGE: Years 0 Months 3 Days 15 If less than one day ... hrs. ... min.
9. Birthplace Chestertown Kent Co Md
(Town, county, and state)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name Edward Collins
13. Birthplace Chestertown Md
MOTHER 14. Maiden name Ida Hudson
15. Birthplace Talbot Co Md
16. Informant Edward Collins (Father)
Address Chestertown Md
17. BURIAL Date thereof Feb 11, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory CHESTER
Location CHESTERTOWN, Md.
18. Funeral director J. Willis Willey
Address Chestertown, Md.
19. Feb. 9 1945 Clara S. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9, 1945, at 8 A M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...; and that I last saw h... alive on ... 19...
Did not attend (Signed Certificate as Deputy Med Examiner Kent Co Md)
Immediate cause of death Probable
Due to Thymus Gland
Due to Disease.
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? None
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE David Hines M.D. Deputy Med Exam Kent Co
M. D. or other
Address Chestertown Md Date signed 2/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

01828

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred:
205 Cross St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Same County:

City or town: Same
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elizabeth Horan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	brown	widowed

6.(b) Name of husband or wife: William Horan

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE:

Years	Months	Days	If less than one day
54	unknown	unknown	unknown hrs. min.

8. Birthplace: Kent County (Town, county, and state)

10. Usual occupation: General House Work

11. Industry or business:

FATHER
12. Name: Lewis Ringgold
13. Birthplace: Kent County

MOTHER
14. Maiden name: Mary Lindsey
15. Birthplace: Kent County

18. Informant: Estella Grafes

Address: R.3, Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 22 45 (month) (day) (year)

Cemetery or crematory: Quaker Neck

Location: Church Lane

18. Funeral director: Asbury & Kenny

Address: Chestertown Md.

19. Feb. 24, 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17, 1945, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19.. to Feb 16 1945 and that I last saw h.. alive on Feb 17 1945

Immediate cause of death	DURATION
Coronary endocarditis	last 1 week
Due to Influenza	3 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. G. Simpers M. D. or other

Address: Chestertown Date signed: 2-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157 MM)

CERTIFICATE OF DEATH

01829

Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Piney Neck

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James Thomas Edwards

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Wh.	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): February 13 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 25 min.

9. Birthplace: Rock Hall, Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Roland D. Edwards

13. Birthplace: Rock Hall, Md

MOTHER

14. Maiden name: Elizabeth Anna Smith

15. Birthplace: Rock Hall, Md

16. Informant: Eliz. Anna Edwards

Address: Rock Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14. 1945 (month) (day) (year)

Cemetery or ~~crematory~~: Wesley Chapel

Location: Rock Hall Md.

18. ~~Funeral director~~: Roland D. Edwards.

Address: Rock Hall Md

19. 2/14 1945 — S Elwood Burgess

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1945 at 4 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 2 25 PM 1945 to Feb 13 4 10 PM 1945

and that I last saw h... alive on 2-13-45 1945

Immediate cause of death	DURATION
Prematurity 8 m.	
Due to: Malformation of both arms and legs.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?): —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. ~~or other~~

Address: Rock Hall, Md Date signed 2/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

01839

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County Kent
City or town Chestertown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Robert Hadaway

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ella May Harris
6.(c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) January 17 - 1889

8. AGE: Years	Months	Days	If less than one day
56	0	17	hrs. min.

9. Birthplace Kent Co. Md Chestertown Md
(Town, county, and state)
10. Usual occupation Merchant
11. Industry or business General Food Store
FATHER 12. Name Daniel Webster Hadaway
FATHER 13. Birthplace Kent Co Md
MOTHER 14. Maiden name Alice C Jones
MOTHER 15. Birthplace Kent Co Md
16. Informant Mrs John Hadaway
Address Chestertown Md
17. Burial Date thereof 2/10/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Quaker
Location Chestertown Maryland
18. Funeral director Marion G. Williams
Address Chestertown, Maryland
19. Feb. 9 1945 Clara L. Barnes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1945, at 9.05 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1944 to Feb 7 1945
and that I last saw him alive on February 7 1945

	DURATION
Immediate cause of death Coronary Occlusion	7 days
Due to Hypertension Disease	4 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank A Smith M. D. or other
Address Chestertown Date signed 2/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01831

Reg. Diat. No. 203.

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Yrs 8 mos

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Yrs 8 mos

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: adela Virginia Harrison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	white	married

B.(b) Name of husband or wife: Richard Harrison

B.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): August 29 1873

8. AGE:

Years	Months	Days	If less than one day
71	6	3	hrs. min.

9. Birthplace: Chesapeake city, Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: own home

FATHER

12. Name: Thomas Warren

13. Birthplace: not known

MOTHER

14. Maiden name: not known

15. Birthplace

16. Informant: Richard Harrison

Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 4 1945 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: near Rock Hall, Md

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Feb 2. 1945 (Date rec'd by registrar) S. Elwood Burgard registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1 1945, at 9 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944 to Feb. 1 1945

and that I last saw h.. alive on June 25 1945

Immediate cause of death	DURATION
chron Endo-Myocarditis	
decompensation	
Due to: ascites	
chron Bronchitis	
Due to:	
Other conditions: —	

(Includes pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Elwood Burgard M. D. or other

Address: Rock Hall, Md Date signed 2/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01832

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: No
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas F. Healey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1899

8. AGE: Years	Months	Days	If less than one day
45	5	0	hrs. min.

9. Birthplace: Waterbury Conn.
(Town, county, and state)
10. Usual occupation: Attorney at Law
11. Industry or business: Practing Law
FATHER 12. Name: Patrick Healey
13. Birthplace: Waterbury Conn.
MOTHER 14. Maiden name: Joanna Fitzgerald
15. Birthplace: Water bury Conn.
16. Informant: Wm. Fitzgerald
Address: 20 East Main St. Waterbury Conn.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/45 (month) (day) (year)
Cemetery or crematory: New St. Joseph
Location: Waterbury, Conn.
18. Funeral director: Marvin V. Williams
Address: Chestertown, Md.
19. Feb. 9 1945 (Date rec'd by registrar) Clarad. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6. 1945 19 at 11.40 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19 and that I last saw h alive on 19

Did not attend signed certificate after Investigation of death as Deputy Med. Exam. Kent Co Md

Immediate cause of death: Coronary Thrombosis
Chronic Myocarditis Diabetes

	DURATION
Due to:	
Due to:	
Other conditions:	

(Incinde pregnancy within 3 months of death)

Major findings at operation: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) None (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Granville Haines M D
M. D. or other
Address: Chestertown Md Date signed: 2/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22nd)

CERTIFICATE OF DEATH

01833

Reg. Diat. No. 2021

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 222 Lynchburg ST

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John William Heath

3.(b) Social Security Number: 210-10-7849

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Not Known

6.(b) Name of husband or wife:

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): June 29 1879

8. AGE: Years	Months	Days	If less than one day
65	7	9	... hrs. ... min.

9. Birthplace: Fort Lonq, South Carolina (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: Vita Wood, Chestertown

FATHER — 12. Name: Not Known

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: Maggie Ingram

MOTHER — 15. Birthplace: Not Known

16. Informant: Mrs Mary Miller

Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10, 1945 (month) (day) (year)

Cemetery or crematory: Quaker Neck Cem.

Location: Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Feb. 7 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7 1945 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3rd 1945 to Feb 7 1945

and that I last saw him alive on 2-6 1945

Immediate cause of death	DURATION
Chron Endo-Myocarditis	
Hypertension	
Due to cerebral accident	
Due to Paralysis of right arm.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 2/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01834

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Rural Millington
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Kent
City or town: Rural Millington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Nancy Lee Hurd

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife: Child

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 27 1944

8. AGE: Years	Months	Days	If less than one day
	6		hrs. min.

9. Birthplace: Kent (town, county, and state) Maryland

10. Usual occupation: Child

11. Industry or business

FATHER — 12. Name: Albert L Hurd

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Mildred Prince

MOTHER — 15. Birthplace: Md.

16. Informant: Albert L Hurd
Address: Rural Millington Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 24 1945 (month) (day) (year)

Cemetery or crematory: Johnstown

Location: Map Earleville Md.

18. Funeral director: Edward Kellum
Address: Millington Md.

19. Feb. 24 1945 (Date rec'd by registrar) Meriett Prince Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 20th 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17th 1945 to Feb 20th 1945, and that I last saw her alive on Feb. 20th 1945

Immediate cause of death	Broncho-Pneumonia	DURATION
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: G. L. Copeland M. D. or other
Address: Millington — Date signed: Feb 25 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

01835

Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Hosana Rebecca Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	widowed

6.(b) Name of husband or wife: Charles Henry Jones

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 11 1861

8. AGE:

Years	Months	Days	If less than one day
83	7	30	...hrs. ...min.

9. Birthplace: Kent Co Md (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: own home

FATHER

12. Name: George R. Reed

13. Birthplace: not known

MOTHER

14. Maiden name: Frances Priestons

15. Birthplace: not known

16. Informant: Maurice Jones

Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/12/45 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall, Maryland

18. Funeral director: Maurice G. Williams

Address: Chestertown, Maryland

19. 2/12 1945 J. Elwood Pearson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1945, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 2 1945, to Feb. 10 1945 and that I last saw h.. alive on 2-9- 1945

Immediate cause of death	DURATION
Chron. Endo-Myocarditis	
Accompanied by	
Due to Hypertension	
Due to old age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of ...

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed 2/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAR 2 1965
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

01836

CERTIFICATE OF DEATH

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: 345 Calvert St.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: Chestertown, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 345 Calvert St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Janie King

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Clk / West King

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 8 1864

8. AGE: Years	Months	Days	If less than one day
80	1	22	..... hrs. ..... min.

9. Birthplace: Kent Co. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: None

FATHER 12. Name: Phillip Bowser

FATHER 13. Birthplace: Chestertown, Md.

MOTHER 14. Maiden name: Martha Rhoda Gale

MOTHER 15. Birthplace: Chestertown Md.

16. Informant: Kent Co. Welfare Records

Address: Chestertown, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/4/45 (month) (day) (year)

Cemetery or crematory: Rich Neck

Location: Near Chestertown — Queen Anne Co.

18. Funeral director: Marion L. Williams

Address: Chestertown Maryland.

19. Feb. 4, 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 26 1945, to Feb 1 1945 and that I last saw h.. alive on Feb. 1 1945

Immediate cause of death	DURATION
Cerebral Hemmorhage	6 days
Due to: high blood pressure	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. Wm. Richmond M. D. or other

Address: Chestertown, Md. Date signed: Feb 4, 45

Lora Blake

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01837

Reg. Dist. No. 2021

1. PLACE OF DEATH:

County: Kent

City or town: Johnsontown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or Street address where death occurred: Chestertown R.D.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Johnsontown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Linly Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widowed

6.(b) Name of husband or wife: (Late) Thelma Linly

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 15. 1867

8. AGE:

Years	Months	Days	If less than one day
77	3	9	hrs. min.

9. Birthplace: Quaker Neck, Kent Co. Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER

12. Name: James Isaac Linly

13. Birthplace: Quaker Neck. Kent Co. Md

MOTHER

14. Maiden name: Sarah Wilson

15. Birthplace: Sarah Wilson

16. Informant: Margaret Brady

Address: Chestertown R D med

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/45 (month) (day) (year)

Cemetery or crematory: Quaker Neck

Location: Pomona, Kent Co. Maryland

18. Funeral director: Marvin C. Williams

Address: Chestertown, Maryland

19. Feb. 27 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1945 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 1944 to Feb 24 1945; and that I last saw alive on Feb 16 1945; that death was due to the following causes:

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Hines M.D. M. D. or other

Address: Chestertown Md Date signed: Feb 27 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

01838

CERTIFICATE OF DEATH

Reg. Dist. No. 201

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Kent
City or town: Still Pond Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Still Pond
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Abraham Lincoln McGill
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Martha Lillian McGill
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): June 8. 1886
8. AGE: Years 58 / 55; Months 17; Days 76; If less than one day ... hrs. ... min.
9. Birthplace: Florence S.C. (Town, county, and state)
10. Usual occupation: Minister
11. Industry or business: Preaching
FATHER 12. Name: Thomas McGill
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Isabella Wright
15. Birthplace: South Carolina
16. Informant: Martha Lillian McGill
Address: Still Pond Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 10 1945 (month) (day) (year)
Cemetery or crematory: Darlington
Location: Florence South Carolina
18. Funeral director: B R Fellows
Address: Still Pond Md
19. Feb 6 1945 (Date rec'd by registrar) J. W. Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3 1945, at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 to 19 and that I last saw h alive on [illegible] 19
Immediate cause of death: Coronary Thrombosis — Duration: [illegible]
Due to: Chronic Myocarditis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? none (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. Signature: [illegible] Dep'ty Med. Exam. Kent Co. M. D. or other
Address: Chestertown, Md Date signed: 2/3/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

01839

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: 222 Kent Circle

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 222 Kent Circle

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edith B. Newnam

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Howard C. Newnam

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): March 16 1895

8. AGE: Years: 49 Months: 9 Days: 9 If less than one day: hrs. min.

9. Birthplace: Pink Hall Kent Co. Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER — 12. Name: John F. Collins

FATHER — 13. Birthplace: Pink Hall, Md.

MOTHER — 14. Maiden name: Belle Crouch

MOTHER — 15. Birthplace: Pink Hall, Md.

18. Informant: Howard C. Newnam

Address: 222 Kent Circle, Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/28/45 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Pink Hall, Maryland

18. Funeral director: Marion V. Williams

Address: Chestertown, Maryland

19. Feb. 28, 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1942, to Feb. 25 1945

and that I last saw h[illegible] alive on Feb. 25 1945

Immediate cause of death	DURATION
Coronary Occlusion	1 yr.
Due to Cancer of Breast	1942
Due to [illegible] Metastases	
Other conditions not Contributory to Death	1944

(Include pregnancy within 3 months of death)

Major findings of operations: Cancer of Breast — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank N. Smith M. D. or other

Address: Chestertown Date signed: Feb. 28 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-6

CERTIFICATE OF DEATH

01840

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Kent

City or town: Galena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Galena

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Frank N. Ruth

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: (Lab) Vena Ireland Ruth

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 24 1861

8. AGE: Years 84 | Months 0 | Days 30 | If less than one day ..... hrs. ..... min.

9. Birthplace: Smyrna Delaware (Town, county, and state)

10. Usual occupation: retired Merchant

11. Industry or business: Store - Merchandise Retail

FATHER 12. Name: Samuel B. Ruth

FATHER 13. Birthplace: Delaware

MOTHER 14. Maiden name: Melvina Hazel

MOTHER 15. Birthplace: Smyrna Delaware

16. Informant: Mrs. Warren Gillespie

Address: Galena, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)

Cemetery or crematory: Christ M. E.

Location: Galena, Maryland

18. Funeral director: Warren L. Gillespie

Address: Chestertown, Md.

19. Feb. 25 1945 (Date rec'd by registrar) Elizabeth J. Medford Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23 1945, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23d 1945, to Feb 23d 1945 and that I last saw h alive on Feb 23d 1945

Immediate cause of death	DURATION
Myocardial Disease	1 mo.
Due to: Hypertension	7 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: G. S. Copeland M. D. or other

Address: Millington Date signed Feb. 24, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

01841

Reg. Dist. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Kent
City or town near Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 74 years
Hospital, institution, or street address where death occurred:
none
How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Rock Hall Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ~

3.(a) FULL NAME Adam Ulysses Smith

3.(b) Social Security Number ~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 8. 1868

8. AGE: Years	Months	Days	If less than one day
76	2	12	hrs. min.

9. Birthplace Leigh Co. Pennsylvania (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name David A Smith

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Emma Smith Smith

15. Birthplace Pennsylvania

16. Informant Samuel Smith

Address Rock Hall Md

17. Burial Date thereof 2/23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul

Location Near Fairlee Kent Co. Md

18. Funeral director Marvin V. Williams

Address Chestertown, Maryland.

19. 2/23 1945 Sidwood Burgin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20 1945, at 12 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1944, to February 20 1945 and that I last saw alive on February 20 1945

Immediate cause of death	DURATION
Secondary Anemia	1 mo
Due to Purpura Thrombopenia	2 mo.
Due to Enlarged Spleen	2 mo.
Other conditions Endocarditis	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Grant W. Smith
M. D. or other

Address Chestertown Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

D1842

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Kent and Queen Anne's Hospital
How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Worton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Frank Ivin Sollaway

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 11, 1943

8. AGE: Years: 1 | Months: 7 | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Chestertown, Kent, Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: James Horace Sollaway
13. Birthplace: Kent County, Md

MOTHER
14. Maiden name: Rhoda Williams
15. Birthplace: Kent County, Md

16. Informant: J. Horace Sollaway (father)
Address: Worton Chestertown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/4/45 (month) (day) (year)
Cemetery or crematory: Chester
Location: Chestertown, Maryland

18. Funeral director: Marvin L. Williams
Address: Chestertown, Maryland

19. Feb 4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2 1945 at 9:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-2-45 to 2-2-45 and that I last saw h.i.m. alive on 2-2 1945

Immediate cause of death	DURATION
2d & 3d degree burns of entire body, except palms & soles	6 hours
Due to Head in [fell in tub of scalding water	
Due to on floor of kitchen.]	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? Worton (City or town) Kent (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury fell in tub of hot water Injured at work? No

23. SIGNATURE: A.C. Dick, M.D. (M. D. or other)
Address: Chestertown Md Date signed 2-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11843

Reg. Dist. No. 201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Kent
City or town: Still Pond
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Parker Arlena Stewart

3.(b) Social Security Number

4. Sex: Female | 5. Color or race: Colored | 6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 11. 1880

8. AGE: Years: 64 | Months: 6 | Days: | If less than one day: hrs. min.

9. Birthplace: Kent Co Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: Geo H Hackett
13. Birthplace: Kent Co Md

MOTHER
14. Maiden name: Victoria Dunn
15. Birthplace: Kent Co Md

16. Informant: Bascom Lee Stewart
Address: Still Pond Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15/45 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Still Pond

18. Funeral director: R R Fellows
Address: Still Pond Md

19. Feb 15 1945 (Date rec'd by registrar) J H Colvin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11 1945 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1945 to Feb 11 1945
and that I last saw h[illegible] alive on Feb 11 1945

Immediate cause of death: Septic Infection — DURATION: Few days
Due to: Gangrene of leg — 5 wks
Due to: Diabetes — 2 years
Other conditions: —
(Include pregnancy within 3 months of death) None

Major findings of operations: Date of op.
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David Hines M.D. M. D. or other
Address: Chestertown Md Date signed: Feb 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

Reg. Diat. No. 11 18443

1. PLACE OF DEATH:
County Kent
City or town near Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Rock Hall R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Swan Neck Quaker Neck
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Harry Arnold Thompson

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Addie Lyle Parsons
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) October 14 1876

8. AGE: Years	Months	Days	If less than one day
68	4	23	...hrs. ...min.

9. Birthplace Chestertown Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Retired
FATHER 12. Name J. Henry Thompson
13. Birthplace Queen Anne's Co Md
MOTHER 14. Maiden name Deborah Susan Parsons
15. Birthplace Kent Co Md
16. Informant Mrs. Mary Thompson
Address Rock Hall Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 9 1945 (month) (day) (year)
Cemetery or crematory Wesley Chapel
Location Rock Hall Md.
18. Funeral director Edgar L. Lasee
Address Church Hill Md
19. 2/9 1945 (Date rec'd by registrar) S. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1945, at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 1944, to Feb. 6 1945
and that I last saw him alive on Feb 6, 1945

Immediate cause of death	DURATION
(a) Pulmonary Tuberculosis	2 days
Due to (b) Surgical Operation	10 years
Due to (c)	
Other conditions Endocarditis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Frederick Smith M. D. or other
Address Chestertown Date signed 2/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

0 1845

Reg. Dist. No. 204

1. PLACE OF DEATH:

County: Kent

City or town: near Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred: Res

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: William Lee Wilkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Amy B Lockard

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): September 3. 1870

8. AGE: Years: 74 | Months: 5 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Kent Co. Md (Town, county, and state)

10. Usual occupation: Commercial Fisherman

11. Industry or business:

FATHER — 12. Name: Edward Wilkins

13. Birthplace: Baltimore

MOTHER — 14. Maiden name: Eugenia Bottom

15. Birthplace: Baltimore

16. Informant: Mrs Mildred Wilkins Wife

Address: Chesterlawn Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Feb 8, 1945 (month) (day) (year)

Cemetery or crematory: Silver Brook

Location: Wilmington, Delaware

18. Funeral director: Wells

Address: Chesterlawn R.R. #4

19. 2/5/45 (Date rec'd by registrar) Frank W. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1945 at 2.25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Feb 5 1945 and that I last saw h alive on Feb 5 1945

	DURATION
Immediate cause of death: Cardiac Vascular Disease	2 years
Due to: C.V. Hemiplegia	May 1943
Due to:	
Other conditions: Hypertension Diabetes Cataracts	4 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank W. Smith M. D., or other

Address: Chestertown Date signed: 2/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15